

Office of Health Care Assurance

State Licensing Section

## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Gabriel Care Home	CHAPTER 100.1
Address: 94-1034 Awanani Street, Waipahu, Hawaii 96797	Inspection Date: December 30, 2019 Annual

**THIS PAGE MUST BE SUBMITTED WITH YOUR PLAN OF CORRECTION. IF IT IS NOT, YOUR PLAN OF CORRECTION WILL BE RETURNED TO YOU, UNREVIEWED.**

**YOUR PLAN OF CORRECTION MUST BE SUBMITTED WITHIN TEN (10) WORKING DAYS. IF IT IS NOT RECEIVED WITHIN TEN (10) WORKING DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.**

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (b)</p> <p>All individuals who either reside or provide care or services to residents in the Type I ARCH shall have documented evidence of an initial and annual tuberculosis clearance.</p> <p><b><u>FINDINGS</u></b> Substitute Care Giver (SCG) #1, no evidence of tuberculosis skin test results 12/09/2019 for conversion to positive PPD.</p> <p>Submit documentation with the plan of correction (POC).</p>	<p style="text-align: center;"><b>PART 1</b></p> <p style="text-align: center;"><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p>SCG was given tuberculosis skin test on 11/27/19 and result was positive 11/29/19. Picked PPD result at doctor's office.</p> <p>PPD + X-RAY copy</p>	<p>01/08/2020</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (b)</p> <p>All individuals who either reside or provide care or services to residents in the Type I ARCH shall have documented evidence of an initial and annual tuberculosis clearance.</p> <p><b><u>FINDINGS</u></b> Substitute Care Giver (SCG) #1, no evidence of tuberculosis skin test results 12/09/2019 for conversion to positive PPD.</p> <p>Submit documentation with the plan of correction (POC).</p>	<p style="text-align: center;"><b>PART 2</b></p> <p style="text-align: center;"><b><u>FUTURE PLAN</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p><i>Either who is reside or provide care or services to pt. in a care home shall have evidence of an initial and annual tuberculosis clearance.</i></p> <ol style="list-style-type: none"> <li><i>1. First shall have skin test or steps skin test for first time residing as a family. This is apply also to NEW resident in a care home.</i></li> <li><i>2. If skin test result is positive. Doctor will issue a chest X-RAY referral to have X-RAY. Then Doctor receive the Chest X-RAY result.</i></li> <li><i>3. Annual tuberculosis Clearance. Doctor will decide according to his/her attestation screening for tuberculosis. If indicate you are having the following problem. If pulmonary TB system are present, a standart is required a Chest X-RAY.</i></li> </ol>	<p style="text-align: right;">1/28/2020</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-14 <u>Food sanitation.</u> (c) Refrigerators shall be equipped with an appropriate thermometer and temperature shall be maintained at 45°F or lower. No refrigerator</p> <p><b><u>FINDINGS</u></b> No thermometer used to maintain temperature for:</p> <ol style="list-style-type: none"> <li>1. Refrigerator in the resident dining area</li> <li>2. Refrigerator in the kitchen used to prepare meals</li> </ol> <p>Thermometer must be inside the refrigerator and checked.</p>	<p style="text-align: center;"><b>PART 1</b></p> <p style="text-align: center;"><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p><i>Both (2) refrigerators residents and family (second floor) that I found 2 thermometers of both refrigerator which was misplaced inside the refrigerator. Thermometer of both refrigerators still maintain temperature. Placed both refrigerator thermometer properly where I can see or easy to spot check refrigerator temperature when I open the door of the both refrigerator.</i></p>	<p style="text-align: right;"><i>1/28/2020</i></p>

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<input checked="" type="checkbox"/>	<p>§11-100.1-14 <u>Food sanitation.</u> (c) Refrigerators shall be equipped with an appropriate thermometer and temperature shall be maintained at 45°F or lower. No refrigerator</p> <p><b><u>FINDINGS</u></b> No thermometer used to maintain temperature for:</p> <ol style="list-style-type: none"> <li>1. Refrigerator in the resident dining area</li> <li>2. Refrigerator in the kitchen used to prepare meals</li> </ol> <p>Thermometer must be inside the refrigerator and checked.</p>	<p style="text-align: center;"><b>PART 2</b></p> <p style="text-align: center;"><b><u>FUTURE PLAN</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p><i>Place thermometer in same place and check easy to check where thermometer. Anytime you want to check the temperature is correct and shall be maintain 45°F or lower.</i></p>	<p style="text-align: right;"><i>12/31/19</i></p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-14 <u>Food sanitation.</u> (f) Toxic chemicals and cleaning agents, such as insecticides, fertilizers, bleaches and all other poisons, shall be properly labeled and securely stored apart from any food supplies.</p> <p><u>FINDINGS</u> Bedroom #4, "Sharps" container at bedside, unsecured.</p>	<p style="text-align: center;"><b>PART 1</b></p> <p style="text-align: center;"><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p><i>I ask pt. 1 to remove sharp container and place to secured and lock room.</i></p>	<p style="text-align: center;"><i>12/31/19</i></p>

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<input checked="" type="checkbox"/>	<p>§11-100.1-14 <u>Food sanitation.</u> (f) Toxic chemicals and cleaning agents, such as insecticides, fertilizers, bleaches and all other poisons, shall be properly labeled and securely stored apart from any food supplies.</p> <p><b><u>FINDINGS</u></b> Bedroom #4, "Sharps" container at bedside, unsecured.</p>	<p style="text-align: center;"><b>PART 2</b></p> <p style="text-align: center;"><b><u>FUTURE PLAN</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p style="text-align: center;"><i>If both of us need it. I can bring out and return sharp container in secured / lock room.</i></p>	<p style="text-align: right;"><i>12/31/19</i></p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN.</p> <p><u>FINDINGS</u> Resident #1, incomplete order (10/30/19) "Calcium &amp; D3" supplement; however, supplement made available daily since July 1, 2019. Please submit with the POC evidence of supplement strength, dose, route and frequency in the order.</p> <p><i>Please submit order with proof of correction</i></p>	<p style="text-align: center;"><b>PART 1</b></p> <p style="text-align: center;"><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p><i>Ask NEW prescription Calcium 600mg + D3 400IU take 1 tablet daily.</i></p> <p><i>Attached Physician Order</i></p>	<p><i>01/02/2020</i></p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications</u>. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN.</p> <p><b><u>FINDINGS</u></b> Resident #1, incomplete order (10/30/19) "Calcium &amp; D3" supplement; however, supplement made available daily since July 1, 2019. Please submit with the POC evidence of supplement strength, dose, route and frequency in the order.</p>	<p style="text-align: center;"><b>PART 2</b></p> <p style="text-align: center;"><b><u>FUTURE PLAN</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p><i>When I pick up a prescription at the pharmacy and label does not match the order. I will call the Doctor that this particular medication doesn't match the order either on strength, route, doses or frequency. I inquire also the pharmacy what Doctor ordered. For second pick up, check again the prescription is match the order.</i></p>	<p style="text-align: right;"><i>1/28/2020</i></p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (f) Medications made available to residents shall be recorded on a flowsheet. The flowsheet shall contain the resident's name, name of the medication, frequency, time, date and by whom the medication was made available to the resident.</p> <p><b>FINDINGS</b> Resident #1, medication administration record (MAR) does not reflect "PRN" medication order as ordered. I.e.,</p> <ol style="list-style-type: none"> <li>Order (10/30/19) reads, "Ammonium Lactate 12% lotion Apply 1-2 times to dry itchy skin <u>as needed</u>"</li> <li>MAR reads, "Ammonium Lactate 12% lotion generic for Lachydrin apply <u>1-2 daily -- given 1x daily</u>"</li> </ol> <p>Notify physician if resident needs PRN medication daily. Record communication in progress notes for new order.</p>	<p style="text-align: center;"><b>PART 1</b></p> <p style="text-align: center;"><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p style="text-align: center;">ASK NEW PRESCRIPTION</p> <p style="text-align: center;">Ammonium Lactate 12% lotion</p> <p style="text-align: center;">Apply daily to dry itchy skin</p> <p style="text-align: center;">Attached copy</p>	<p style="text-align: right;">01/02/2020</p>

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<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (f) Medications made available to residents shall be recorded on a flowsheet. The flowsheet shall contain the resident's name, name of the medication, frequency, time, date and by whom the medication was made available to the resident.</p> <p><b>FINDINGS</b> Resident #1, medication administration record (MAR) does not reflect "PRN" medication order as ordered. I.e.,</p> <ol style="list-style-type: none"> <li>1. Order (10/30/19) reads, "Ammonium Lactate 12% lotion Apply 1-2 times to dry itchy skin <u>as needed</u>"</li> <li>2. MAR reads, "Ammonium Lactate 12% lotion generic for Lachydrin apply <u>1-2 daily - given 1x daily</u>"</li> </ol> <p>Notify physician if resident needs PRN medication daily. Record communication in progress notes for new order.</p>	<p style="text-align: center;"><b>PART 2</b></p> <p style="text-align: center;"><b><u>FUTURE PLAN</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p>① Write DC (discontinue) and date on same line on PRN medication.</p> <p>② Pt's Mar - New Doctor's prescription "DAILY"</p> <p>ON NEXT LINE:</p> <p>First column - write date ordered 2nd column - "medication" - write medication name, directions includes strength, dose, frequency.</p> <p>3rd column: hrs when to administer top.</p> <p>4th column: Need initials of care giver when you administer the meds. to pt gd.</p>	<p style="text-align: right;">1/28/2020</p>

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<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (g) All medication orders shall be reevaluated and signed by the physician or APRN every four months or as ordered by the physician or APRN, not to exceed one year. Resident #1</p> <p><b>FINDINGS</b> Resident #1, medication order reevaluated and signed for a period greater than four months. I.e., Manually signed order dated 3/14/19 and electronic signature order dated 10/30/19.</p>	<p style="text-align: center;"><b>PART 1</b></p> <p style="text-align: center;">Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</p>	<p style="text-align: right;"> <small>           01/14/2020            01/14/2020            01/14/2020            01/14/2020         </small> </p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (b)(3) During residence, records shall include:</p> <p>Progress notes that shall be written on a monthly basis, or more often as appropriate, shall include observations of the resident's response to medication, treatments, diet, care plan, any changes in condition, indications of illness or injury, behavior patterns including the date, time, and any and all action taken. Documentation shall be completed immediately when any incident occurs;</p> <p><b><u>FINDINGS</u></b> Resident #1, progress notes do not reflect the following:</p> <ol style="list-style-type: none"> <li>1. Observations for the resident response to prn medication for itchy skin</li> <li>2. Monthly vital signs related to cardiovascular medications</li> <li>3. Reason for bandage on right hand</li> </ol>	<p style="text-align: center;"><b>PART 1</b></p> <p style="text-align: center;">Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</p>	<p style="text-align: right;"> <small>OFFICE OF THE STATE COMMISSIONER OF HEALTH SERVICES</small>  <small>750 WEST WASHINGTON STREET, SUITE 1000, BALTIMORE, MD 21201</small>  <small>750 WEST WASHINGTON STREET, SUITE 1000, BALTIMORE, MD 21201</small> </p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (b)(8) During residence, records shall include:</p> <p>Notation of visits and consultations made to resident by other professional personnel as requested by the resident or the resident's physician or APRN;</p> <p><b><u>FINDINGS</u></b> Resident #1, no description in progress notes for:</p> <ol style="list-style-type: none"> <li>1. 01/17/19, PCP appointment</li> <li>2. 03/14/19, PCP appointment</li> <li>3. 11/20/19, eye appointment</li> </ol>	<p style="text-align: center;"><b>PART 1</b></p> <p style="text-align: center;">Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</p>	<p style="text-align: right;"> <small>           RECEIVED            01/17/19            03/14/19            11/20/19            02/15/19         </small> </p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (b)(8) During residence, records shall include:</p> <p>Notation of visits and consultations made to resident by other professional personnel as requested by the resident or the resident's physician or APRN;</p> <p><b><u>FINDINGS</u></b> Resident #1, no description in progress notes for:</p> <ol style="list-style-type: none"> <li>1. 01/17/19, PCP appointment</li> <li>2. 03/14/19, PCP appointment</li> <li>3. 11/20/19, eye appointment</li> </ol>	<p style="text-align: center;"><b>PART 2</b></p> <p style="text-align: center;"><b><u>FUTURE PLAN</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p><i>In future, I will include notation of visits and resident's physician. This <del>include</del> include what particular doctor's follow up. Discussion during session will be noted in progress notes and shall be completed immediately.</i></p>	<p style="text-align: right;"><i>01/10/2020</i></p> <p style="text-align: right;"><small>UNIVERSITY OF MARYLAND STATE COLLEGE 9300 VINEYARD</small></p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (c)            Unusual incidents shall be noted in the resident's progress notes. An incident report of any bodily injury or other unusual circumstances affecting a resident which occurs within the home, on the premises, or elsewhere shall be made and retained by the licensee or primary care giver under separate cover, and shall be made available to the department and other authorized personnel. The resident's physician or APRN shall be called immediately if medical care may be necessary.</p> <p><b><u>FINDINGS</u></b>            Resident #1, no evidence of incident report for injury to hand on 12/30/19 resulting in SCG bandaging right hand.</p>	<p style="text-align: center;"><b>PART 1</b></p> <p style="text-align: center;"><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p style="text-align: center;"><i>Incident report was made            12/30/19 2pm.            Noted in the residents            progress notes.</i></p>	<p style="text-align: center;"><i>12/30/19</i></p> <p style="text-align: right;"> <small>MISSISSIPPI DEPARTMENT OF HEALTH SERVICES            DIVISION OF LICENSING            7578 DLR 02</small> </p>

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*beside (R) side bed to prevent from scripping cement wall.*

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (e)            In the event of an emergency, an oral summary of the resident's condition shall be provided to the receiving facility, followed by a written transfer summary.</p> <p><b><u>FINDINGS</u></b>            Resident #1, emergency sheet not current. I.e., no information for the current medications, current TB clearance and current diet (Regular diet).</p>	<p style="text-align: center;"><b>PART 1</b></p> <p style="text-align: center;">Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</p>	<p style="text-align: right;"> <small>               JUN 14 2014                10:25 AM                VS: 20 71 NW 02             </small> </p>

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<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (e)            In the event of an emergency, an oral summary of the resident's condition shall be provided to the receiving facility, followed by a written transfer summary.</p> <p><b><u>FINDINGS</u></b>            Resident #1, emergency sheet not current. I.e., no information for the current medications, current TB clearance and current diet (Regular diet).</p>	<p style="text-align: center;"><b>PART 2</b></p> <p style="text-align: center;"><b><u>FUTURE PLAN</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p><i>I will renew emergency form after resident annual PE.</i></p> <p><i>If order for medicine and diet were changed, I will update the form.</i></p> <p><i>For new admission, I will complete the form in the day of admission.</i></p>	<p style="text-align: right;"><i>01/03/19</i></p> <p style="text-align: right;"> <small>STATE OF CONNECTICUT            DEPARTMENT OF SOCIAL SERVICES            STATE OF CONNECTICUT            DEPARTMENT OF SOCIAL SERVICES</small> </p> <p style="text-align: right;"> <small>JUN 14 2:54 PM '20</small> </p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-23 <u>Physical environment.</u> (h) The Type I ARCH shall maintain the entire facility and equipment in a safe and comfortable manner to minimize hazards to residents and care givers.</p> <p><b><u>FINDINGS</u></b> Water leaking from ceiling onto the resident dining table.</p>	<p style="text-align: center;"><b>PART 1</b></p> <p style="text-align: center;"><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p style="text-align: center;"><i>NEW Refrigerator Replaced.</i></p>	<p style="text-align: center;"><i>01/07/2020</i></p>

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<input checked="" type="checkbox"/>	<p>§11-100.1-23 <u>Physical environment.</u> (h) The Type I ARCH shall maintain the entire facility and equipment in a safe and comfortable manner to minimize hazards to residents and care givers.</p> <p><u>FINDINGS</u> Water leaking from ceiling onto the resident dining table.</p>	<p style="text-align: center;"><b>PART 2</b></p> <p style="text-align: center;"><b><u>FUTURE PLAN</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p>I ask my carpenter to check under the floor. carpenter and me observed NO mold, NO Rotten wood OR Woods are dry, and every thing are good condition. Changed/ NBW CEILING.</p>	<p style="text-align: right;">1/28/2020</p>

Licensee's/Administrator's Signature: Juliet S. Gabriel  
Print Name: JULIET S. GABRIEL  
Date: 01/13/2020

Licensee's/Administrator's Signature: Juliet S. Gabriel  
Print Name: JULIET S. GABRIEL  
Date: 1/28/2020

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